Booklet 2

KingCare Basic and Preferred Medical

Aetna
Medical Services

AdvancePCS
Prescription Drug Services

Although these benefit descriptions include certain key features and brief summaries of King County regular employee and part-time Local 587 benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts or other legal documents, the legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

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Overview

► Highlights of Coverage under the KingCare Basic and Preferred Medical Plans

Here are a few highlights of your coverage under the KingCare Basic and Preferred Plans:

- Two separate companies process claims for the plans:
  - Aetna processes all medical claims (physician visits, hospital, lab work, etc.)
  - AdvancePCS processes all outpatient, retail pharmacy and mail order prescription drug claims
- For medical services, you pay an annual deductible before the plans pay for most benefits, then you pay coinsurance for most services
- For prescription drug services:
  - You pay copays for each prescription filled (copays are lowest for generic drugs, higher for preferred brand drugs and highest for non-preferred brand drugs)
  - You may get up to 30-day supplies of prescription drugs at retail pharmacies and up to 90-day supplies through the AdvancePCS mail order service
- For both medical and prescription drug services:
  - Nationwide networks of providers are available but you may use non-network providers
  - When you use network providers your claims are filed automatically
  - When you use non-network providers you must file claims for reimbursement.

► Important Facts

Many important topics – including laws, regulations and county provisions – affect more than just these plans and can change frequently. To be more efficient, and avoid repetition, the following related information appears only once – in the Important Facts booklet:

- Who's eligible for coverage
- How to enroll
- When coverage begins
- Changes you can make to your coverage
- When coverage ends and options for continuing it after you leave employment
- What happens to coverage in different situations
- Your rights and responsibilities under the plans.

Cost

See "Plan Features" for details on deductibles, copays and coinsurance amounts; also see the latest new hire guides and open enrollment materials or www.metrokc.gov/finance/benefits for information about any monthly coverage cost.

Medical Services. When you receive medical care, you pay:

- The annual deductible (does not apply to preventive care or hearing aids)
- Coinsurance amounts not covered by the plans
- Copays for emergency room care
- Amounts in excess of usual, customary and reasonable (UCR) rates if you use non-network providers
- Expenses for services or supplies not covered by the plans.

Prescription Drug Services. When you fill a prescription, you pay:

- Copays for up to a 30-day supply from a network pharmacy:
  - $10 for a generic drug
  - $15 for a preferred brand drug ($20 if generic available, but the $15 copay applies if you're unable to take generic for medical reasons)
  - $25 for a non-preferred brand drug ($30 if generic available, but the $25 copay applies if you're unable to take generic for medical reasons)

- Copays for up to a 90-day supply from the network mail order service:
  - $20 for a generic drug
  - $30 for a preferred brand drug ($40 if generic available, but the $30 copay applies if you're unable to take generic for medical reasons)
  - $50 for a non-preferred brand drug ($60 if generic available, but the $50 copay applies if you're unable to take generic for medical reasons)
- Amounts in excess of the rates AdvancePCS pays its network pharmacies if you use non-network pharmacies.

The annual deductible doesn't apply to prescription drugs.

Preexisting Condition Limit

There is no preexisting condition limit for medical or prescription drug services. However, there is a waiting period for transplants (see "Transplants" under "Covered Expenses under KingCare").

If you end employment with King County, please refer to "Certificate of Coverage" for information on how your participation in the KingCare plans can be credited against other plans with preexisting condition limits.

How the Plans Work

► Plan Features

The following table identifies some plan features, including your annual deductibles, out-of-pocket maximums and how benefits are determined for most covered expenses. The sections following the table contain additional details.

Plan Feature	KingCare Basic Plan	KingCare Preferred Plan
Provider choice	You may choose any qualified provider, but you receive higher coverage when you use network providers Reimbursement for non-network medical services is based on UCR rates, and reimbursement for non-network prescription drug services is based on the rates AdvancePCS pays its network pharmacies; you pay amounts in excess of these rates	You may choose any qualified provider, but you receive higher coverage when you use network providers Reimbursement for non-network medical services is based on UCR rates, and reimbursement for non-network prescription drug services is based on the rates AdvancePCS pays its network pharmacies; you pay amounts in excess of these rates
Annual deductible	$500/person, $1,500/family Deductible amounts applied to charges incurred in the last 3 months of the calendar year are carried over and applied to the next year's deductible Deductible doesn't apply to prescription drugs, preventive care or hearing aids	$100/person, $300/family Deductible amounts applied to charges incurred in the last 3 months of the calendar year are carried over and applied to the next year's deductible Deductible doesn't apply to prescription drugs, preventive care or hearing aids
Copays	Applicable only to emergency room care and prescription drugs (see "Summary of Covered Expenses" for amounts)	Applicable only to emergency room care and prescription drugs (see "Summary of Covered Expenses" for amounts)
After the deductible/copays, the plans pay most covered services at these levels ...	80% network for medical claims 60% non-network for medical claims 100% of network rate after applicable copays for prescription drug claims (deductible does not apply)	90% network for medical claims 70% non-network for medical claims 100% of network rate after applicable copays for prescription drug claims (deductible does not apply)

Plan Feature	KingCare Basic Plan	KingCare Preferred Plan
Until you reach your annual out-of-pocket maximum...	$1,200/person, $2,400/family for network care $2,000/person, $4,000/family for non-network care Does not apply to prescriptions; see "Annual Out-of-Pocket Maximum" for details	$800/person, $1,600/family for network care $1,600/person, $3,200/family for non-network care Does not apply to prescriptions; see "Annual Out-of-Pocket Maximum" for details
Then, most benefits are paid for the rest of the calendar year at ...	100% for network services and 100% of UCR for non-network services	100% for network services and 100% of UCR for non-network services
Lifetime maximum	$2,000,000	$2,000,000

► Network Providers

Medical Services. Aetna is solely responsible for determining which providers participate in its nationwide network. For the KingCare plans, Aetna includes the Ethix network of Puget Sound providers in addition to its regular nationwide network of hospitals, clinics, doctors and other health care professionals. (Non-network providers may contact Aetna to join the Aetna network.)

All network hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations and have a current state license as well as adequate liability insurance. Doctors or other health care professionals meet credentialing requirements including completion of a detailed application that covers education, status of board certification, malpractice and state sanction histories.

For a list of Aetna network providers, contact Aetna (see Resource Directory booklet).

Prescription Drug Services. AdvancePCS contracts with pharmacies that participate in its nationwide network. The network includes all major chain pharmacies and most independent pharmacies, plus a mail order service.

For a list of AdvancePCS network pharmacies, contact AdvancePCS (see Resource Directory booklet).

► Out-of-Area Coverage

For both medical and prescription drug services, nationwide networks are available. Therefore, even when you're out of the area, you may use network providers and pharmacies to receive network coverage almost anywhere.

You may also use non-network providers when you're out of the area. However, when you choose non-network providers you must file your own claims. For medical claims you're reimbursed at UCR rates and for prescription drug claims you're reimbursed at the rates AdvancePCS pays its network pharmacies; you pay amounts non-network providers or pharmacies charge in excess of these rates.

► Annual Deductible

The annual deductible is the amount you must pay each year toward covered benefits before a plan starts paying. The annual deductible for:

- KingCare Basic is $500/person to a maximum of $1,500/family
- KingCare Preferred is $100/person to a maximum of $300/family.

The deductible does not apply to certain covered services and supplies, which means your plan pays for them even if you haven't met the deductible. These include prescription drugs (which require copays), preventive care and hearing aids.

If three or more family members (including yourself) together incur $1,500 in covered expenses for the KingCare Basic Plan ($300 for the KingCare Preferred Plan), you meet the family deductible. This means no further deductible will be required from any family member for the rest of that year.

If you and your family members are in the same accident, only one individual deductible will apply.

The amount you pay toward your deductible during the last three months of any calendar year will also apply toward next year's deductible.

► Annual Out-of-Pocket Maximum

The out-of-pocket maximum applies only to medical services; it does not apply to prescription drug services.

The out-of-pocket maximum is the most you pay in coinsurance for covered medical expenses each year. This means once you reach your out-of-pocket maximum, your KingCare plan pays 100% for most covered expenses for the rest of that year. If you have three or more family members (including yourself), each family member's covered expenses accumulate toward the family out-of-pocket maximum.

The following do not apply to the out-of-pocket maximum:
- Amounts in excess of UCR
- Annual deductible
- Charges beyond benefit maximums
- Coinsurance for smoking cessation programs and outpatient mental health care
- Copay amounts for emergency room care and prescription drugs
- Expenses not covered under the plans.

► Lifetime Maximum

The lifetime maximum applies only to medical services; there is no lifetime maximum for prescription drug services.

The total amount paid for all medical services under the KingCare Basic Plan or the KingCare Preferred Plan is limited to a lifetime maximum of $2,000,000. Up to $20,000 of this maximum is restored automatically at the start of each calendar year for benefits paid during the prior year. Some expenses are also subject to annual or lifetime benefit limits (see "Covered Expenses under KingCare").

► Accessing Care

Medical Services. You may receive network benefits or non-network benefits; the level of coverage depends on the provider you see.

For network benefits:
- You choose an Aetna network provider
- Your network provider obtains preauthorization from Aetna for certain procedures and services
- Your provider files your claims and Aetna reimburses the provider
- You receive an explanation of benefits (EOB) from Aetna, informing you of applicable deductibles, coinsurance and copays and indicating your share of the cost
- You receive a bill from your network provider and pay the provider the amount indicated on EOB.

For non-network benefits:
- You choose a non-network provider
- You must obtain preauthorization from Aetna for certain procedures and services (see "Obtaining Preauthorization")
- You may be required to pay the bill in full and file a claim for reimbursement from Aetna

- Aetna reimburses you based on the non-network benefit at UCR rates; any amount in excess of the UCR rate is your responsibility.

Prescription Drug Services. You may receive network benefits or non-network benefits; the level of coverage depends on the pharmacy you use.

For network benefits:
- You choose an AdvancePCS network pharmacy or the AdvancePCS mail order service
- Your doctor obtains preauthorization for certain prescription drugs and quantities from AdvancePCS
- You pay the appropriate copays to your network pharmacy or AdvancePCS mail order service when you fill your prescriptions
- AdvancePCS pays the pharmacy or processes the claim through its mail order service.

For non-network benefits:
- You choose a non-network pharmacy (there is no non-network mail order service)
- Your doctor obtains preauthorization for certain prescription drugs and quantities from AdvancePCS
- You pay the cost of the prescription in full and file a claim for reimbursement from AdvancePCS
- AdvancePCS reimburses you at the rate it would pay a network pharmacy, less the appropriate copay; any amount in excess of this rate is your responsibility.

► Second Opinions

On occasion, you may want a second opinion from another doctor. To receive network benefits, you must get the second opinion from an Aetna network provider. At any point, you may decide to see a non-network provider and receive non-network benefits.

► Obtaining Preauthorization

Medical Services. If you see an Aetna network provider, the provider will obtain preauthorization for your care as required. If you see a non-network provider, you are responsible for obtaining preauthorization for certain services or supplies. This means you must call or ask your physician to call for preauthorization on your behalf. You may then call Aetna to check that your physician followed through (see Resource Directory booklet).

With preauthorization, benefits will be paid according to plan provisions and limits, if your benefits are in force when you receive care. Aetna will confirm the preauthorization in writing. It will be valid for three months, if your condition does not change.

If you see a non-network provider, you must obtain preauthorization for these covered services:
- Anorexiants for treatment of attention deficit disorder or narcolepsy
- Durable medical equipment
- Growth hormones
- Home health care
- Hospice care
- Injectable prescription drugs (with certain exceptions like insulin, Depo-Provera and some others)
- Inpatient chemical dependency treatment
- Inpatient hospital care (other than for most stays in connection with childbirth)
- Inpatient mental health care
- Inpatient neurodevelopmental therapy for children age six and younger
- Skilled nursing facility care
- TMJ disorders
- Transplants.

If you are having surgery or being admitted to a hospital (except for childbirth), Aetna must be notified at least seven days before the (non-emergency) surgery or admission. Before admission, be sure to confirm with the hospital that your stay has been preauthorized.

You must call Aetna within 48 hours from the start of your care (or as soon as reasonably possible) for:
- Accidents
- Emergencies (including detoxification)
- Involuntary commitment to a Washington state mental hospital
- Maternity admissions.

To obtain preauthorization for non-emergency care (or certification afterward), have your physician contact Aetna at 1-800-654-7714. For chemical dependency treatment or mental health care, you may also call King County's Making Life Easier Program (see Resource Directory booklet). Staff will obtain preauthorization as necessary and refer you to a provider for treatment.

When calling, be prepared to supply these details:
- Admission date
- Diagnosis or surgery
- Employer name (King County)
- Employee name and Social Security number (or unique identifying number if assigned one by the plan)
- Hospital name and address or phone number
- Patient name, address and date of birth
- Physician name and address or phone number
- Proposed treatment plan, including length of stay and discharge planning needs.

If your care is not preauthorized as described above and Aetna determines your care was not medically necessary, the charges for your care may be only partially paid or may not be paid at all.

Prescription Drug Services. Certain prescriptions and quantities require preauthorization. You or your doctor can find out if preauthorization is required by contacting AdvancePCS (see Resource Directory booklet) before you have a prescription filled. Otherwise, your pharmacist or the AdvancePCS mail order service will advise you of the preauthorization procedures required to fill the prescription.

To preauthorize a prescription, your doctor or his/her representative must initiate the process with a phone call to AdvancePCS. Your eligibility is then confirmed and your prescription records checked to see if the prescription has been preauthorized before.

Preauthorization requests are evaluated using criteria approved by your plan; the request is then approved, denied or held for further information. If more information is required, AdvancePCS will notify your physician's office; once the doctor provides the information, your request can be approved or denied.

If the preauthorization is approved, AdvancePCS notifies your physician and updates its database so you can fill the prescription.

If preauthorization is denied, a pharmacist verifies the denial is valid according to plan criteria and then AdvancePCS notifies:
- Your physician verbally
- You and your physician in writing.

When you receive a written denial you may appeal (see "Appealing Denied Claims" in this booklet).

► Case Management

Medical Services. When determined medically necessary as well as care- and cost-effective, Aetna may offer or approve other benefit options on a case-by-case basis. These alternative options will be approved only when traditional benefits would otherwise be available under these plans. For example, when provided at equal or lesser cost, benefits could be available for home health care (instead of hospitalization or other institutional care) by a licensed home health, hospice, or home care agency.

Less expensive or less intensive services will be approved for alternative options only with your consent and when your physician confirms the services are adequate. An approved written treatment plan may be required.

The decision to offer or approve other benefit options remains with Aetna and will be determined based on individual medical needs. The amount of coverage for approved alternative options will not exceed the amount that would otherwise be available for approved traditional benefits.

Prescription Drug Services. AdvancePCS does not determine the maximum number of refills or period when a prescription is valid; these requirements are mandated by federal and state laws regulating pharmacy practices. However, certain drugs must be preauthorized by Advance PCS before they will be covered:

- Attention deficit disorder/narcolepsy medication for patients over age 18
- Growth hormones
- Multiple sclerosis medication
- Oral antifungal medication
- Topical acne medication for patients over 24.

AdvancePCS routinely reviews prescribing guidelines to ensure drugs are clinically appropriate and may limit the quantities of certain drugs to ensure proper utilization. For a list of these drugs, contact AdvancePCS (see the Resource Directory booklet).

Covered Expenses under KingCare

► Summary of Covered Expenses

The following table summarizes covered services and supplies under these plans (only medically necessary services, prescription drugs and supplies are covered) and identifies related coinsurance, copays, maximums and limits. Also see the sections after the table as well as "Expenses Not Covered."

Aetna processes medical claims, AdvancePCS processes outpatient, retail pharmacy and mail order prescription drug claims and, where a benefit involves claims processed by both companies, the information is noted in the following table or in the sections that follow the table.

Covered Expenses	KingCare Basic Plan	KingCare Preferred Plan
Alternative care (including medically necessary acupuncture, hypnotherapy, massage therapy and naturopathy)	80% network 60% non-network Certain services must be prescribed by a physician; Aetna reviews medical necessity of all treatment after 20 visits	90% network 70% non-network Certain services must be prescribed by a physician; Aetna reviews medical necessity of all treatment after 20 visits
Ambulance services	80%	90%
Chemical dependency treatment (requires preauthorization)	80% network 60% non-network $11,285 maximum in 24 consecutive months for combined network and non-network services (maximum subject to annual adjustment)	100% network 70% non-network $11,285 maximum in 24 consecutive months for combined network and non-network services (maximum subject to annual adjustment)
Chiropractic care and manipulative therapy (like all services, must be medically necessary)	80% network 60% non-network Up to 33 visits/year for combined network and non-network services Limited to diagnosis and treatment of musculoskeletal disorders	90% network 70% non-network Up to 33 visits/year for combined network and non-network services Limited to diagnosis and treatment of musculoskeletal disorders

Covered Expenses	KingCare Basic Plan	KingCare Preferred Plan
Circumcision (covered within 31 days of birth; after 31 days if medically necessary)	80% network 60% non-network	90% network 70% non-network
Diabetes care training	80% network when prescribed by your physician 60% non-network when prescribed by your physician	90% network when prescribed by your physician 70% non-network when prescribed by your physician
Diabetes supplies (insulin, needles, syringes, lancets, etc.)	Covered under prescription drugs	Covered under prescription drugs
Durable medical equipment, prosthetics and orthopedic appliances	80% when preauthorized	80% when preauthorized
Emergency room care	80% after $50 copay/visit (waived if admitted) for network or non-network emergency care 80% network, 60% non-network after $50 copay/visit for non-emergency care	90% after $50 copay/visit (waived if admitted) for network or non-network emergency care 90% network, 70% non-network after $50 copay/visit for non-emergency care
Family planning	80% network 60% non-network	90% network 70% non-network
Growth hormones	80% network when preauthorized 60% non-network when preauthorized May also be covered under the prescription drug benefit	90% network when preauthorized 70% non-network when preauthorized May also be covered under the prescription drug benefit
Hearing aids	100% up to $500 in 36 months for combined network and non-network services Deductible does not apply	100% up to $500 in 36 months for combined network and non-network services Deductible does not apply
Home health care	100% when preauthorized up to 130 visits/year for combined network and non-network services	100% when preauthorized up to 130 visits/year for combined network and non-network services
Hospice care	100% when preauthorized 6-month lifetime maximum 120-hour maximum for respite care in any 3-month period	100% when preauthorized 6-month lifetime maximum 120-hour maximum for respite care in any 3-month period
Hospital care	80% network when preauthorized 60% non-network when preauthorized	90% network when preauthorized 70% non-network when preauthorized
Infertility	80% network 60% non-network Limited to specific services and $25,000 lifetime maximum for combined network and non-network services	90% network 70% non-network Limited to specific services and $25,000 lifetime maximum for combined network and non-network services
Injury to teeth	80% network 60% non-network Up to $600/accident for combined network and non-network services	90% network 70% non-network Up to $600/accident for combined network and non-network services
Inpatient care alternatives	80% network when preauthorized 60% non-network when preauthorized	90% network when preauthorized 70% non-network when preauthorized

Covered Expenses	KingCare Basic Plan	KingCare Preferred Plan
Lab, x-ray and other diagnostic testing	80% network 60% non-network	90% network 70% non-network
Massage therapy (see "Alternative care")	80% network 60% non-network	90% network 70% non-network
Maternity care	80% network 60% non-network	90% network 70% non-network
Mental health care (when deemed appropriate, 2 unused outpatient visits may be traded for 1 inpatient day, or vice versa; requires preauthorization)	80% network, 60% non-network for inpatient up to 30 days/year (combined network and non-network services) 50% up to 52 visits/year for outpatient (combined network and non-network services)	90% network, 70% non-network for inpatient up to 30 days/year (combined network and non-network services) 50% up to 52 visits/year for outpatient (combined network and non-network services)
Neurodevelopmental therapy for family members age 6 and under	80% network when preauthorized 60% non-network when preauthorized $2,000/year maximum for combined network and non-network services	90% network when preauthorized 70% non-network when preauthorized $2,000/year maximum for combined network and non-network services
Out-of-area coverage while traveling, for your children away at school, etc.	Same coverage as when home, through Aetna and AdvancePCS national provider networks	Same coverage as when home, through Aetna and AdvancePCS national provider networks
Physician and other medical/surgical services	80% network 60% non-network	90% network 70% non-network
Phenylketonuria (PKU) formula	80% network 60% non-network	90% network 70% non-network
Prescription drugs – up to 30-day supply through network pharmacies	100% after $10 copay for generic 100% after $15 copay for preferred brand ($20 if generic available, but if unable to take it for medical reasons, the $15 copay applies) 100% after $25 copay for non-preferred brand ($30 if generic available, but if unable to take it for medical reasons, the $25 copay applies) Prescriptions filled at non-network pharmacies reimbursed at the rate AdvancePCS pays to network pharmacies, less your copay	100% after $10 copay for generic 100% after $15 copay for preferred brand ($20 if generic available, but if unable to take it for medical reasons, the $15 copay applies) 100% after $25 copay for non-preferred brand ($30 if generic available, but if unable to take it for medical reasons, the $25 copay applies) Prescriptions filled at non-network pharmacies reimbursed at the rate AdvancePCS pays to network pharmacies, less your copay
Prescription drugs – up to 90-day supply through mail order network only	100% after $20 copay for generic 100% after $30 copay for preferred brand ($40 if generic available, but if unable to take it for medical reasons, the $30 copay applies) 100% after $50 copay for non-preferred brand ($60 if generic available, but if unable to take them for medical reasons, the $50 copay applies)	100% after $20 copay for generic 100% after $30 copay for preferred brand ($40 if generic available, but if unable to take it for medical reasons, the $30 copay applies) 100% after $50 copay for non-preferred brand ($60 if generic available, but if unable to take them for medical reasons, the $50 copay applies)

Covered Expenses	KingCare Basic Plan	KingCare Preferred Plan
Preventive care (well-child check-ups, immunizations, routine health and hearing exams, etc.)	100% network 60% non-network Deductible does not apply	100% network 70% non-network Deductible does not apply
Radiation therapy, chemotherapy and respiratory therapy	80% network 60% non-network	90% network 70% non-network
Reconstructive services (includes benefits for mastectomy-related services – reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedema; call plans for more information)	80% network 60% non-network	90% network 70% non-network
Rehabilitative services Inpatient and outpatient	80% network 60% non-network	90% network 70% non-network
Skilled nursing facility	80% network when preauthorized 60% non-network when preauthorized	90% network when preauthorized 70% non-network when preauthorized
Smoking cessation	80% network services 60% non-network services $500 lifetime maximum for smoking cessation services and prescriptions combined (prescriptions covered under "Prescription drugs" benefit)	90% network services 70% non-network services $500 lifetime maximum for smoking cessation services and prescriptions combined (prescriptions covered under "Prescription drugs" benefit)
Temporomandibular joint (TMJ) disorders	80% network when preauthorized 60% non-network when preauthorized Nightguards covered if prescribed by a medical doctor for a TMJ disorder Up to $2,000/calendar year for combined network and non-network services	90% network when preauthorized 70% non-network when preauthorized Nightguards covered if prescribed by a medical doctor for a TMJ disorder Up to $2,000/calendar year for combined network and non-network services
Transplants (certain services only)	100% network when preauthorized 60% non-network when preauthorized Medical coverage must have been continuous for more than 12 months under a KingCare plan – whether preexisting or an emergency	100% network when preauthorized 70% non-network when preauthorized Medical coverage must have been continuous for more than 12 months under a KingCare plan – whether preexisting or an emergency
Urgent care (ear infections, high fevers, minor burns, etc.)	80% network 60% non-network	90% network 70% non-network

► Alternative Care

Covered services include:

- Acupuncture, limited to services for chronic pain symptoms
- Hypnotherapy for chronic pain control or services prescribed by a covered mental health provider specified under "Mental Health Care"
- Massage therapy prescribed by a physician and designed to restore and improve physical functioning lost due to an illness or injury covered under the rehabilitative or neurodevelopmental benefit
- Naturopathy (limited to physical exams, diagnosis, interpretation of lab tests, nutritional counseling for chronic diseases where dietary adjustment has a therapeutic role, and treatment of chronic conditions).

After 20 visits for any of the covered alternative care services listed, Aetna will request your medical records to determine the medical necessity of further treatment.

► Ambulance Services

These plans cover medically necessary emergency ground or air ambulance services to a network facility or the nearest facility where appropriate care is covered.

► Chemical Dependency Treatment

Aetna network providers obtain preauthorization for this care as necessary. If you see a non-network provider, you must obtain preauthorization from Aetna for inpatient chemical dependency treatment. For additional counseling and referral services, you may also call the King County Making Life Easier Program at 1-888-874-7290.

Chemical dependency benefits are covered up to $11,285 in plan payments in 24 consecutive months. (This maximum is effective in 2003 and may be adjusted each year; please refer to the latest new hire guides or open enrollment materials for the current maximum.)

Inpatient and outpatient chemical dependency treatment is covered, including:
- Detoxification services
- Diagnostic evaluation and education
- Organized individual and group counseling
- Prescription drugs and medicines.

Aetna processes claims for prescription drugs used during inpatient hospitalization; AdvancePCS processes claims for outpatient, retail pharmacy and mail order drugs.

► Chiropractic Care and Manipulative Therapy

The plans cover services of licensed chiropractors, up to 33 visits per year, limited to diagnosis and treatment of musculoskeletal disorders, including:
- Diagnostic lab services directly related to the spinal care treatment you are receiving
- Full spinal x-rays
- Non-invasive spinal manipulations.

The plans do not cover spinal manipulations under anesthesia.

► Diabetes Care Training

The plans cover diabetes care training when prescribed by your physician.

► Durable Medical Equipment, Prosthetics and Orthopedic Appliances

Durable medical equipment is covered if:
- Designed for prolonged use
- It has a specific therapeutic purpose in treating your illness or injury
- Prescribed by your physician, and
- Primarily and customarily used only for medical purposes.

Network providers will obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for durable medical equipment.

Medical Services. The following services are covered (Aetna processes the claims):
- Artificial limbs or eyes (including implant lenses prescribed by your provider and required as a result of cataract surgery or to replace a missing portion of the eye)
- Casts, splints, crutches, trusses or braces
- Diabetes equipment for home testing and insulin administration not covered under the prescription drug benefit (excluding batteries)
- Initial external prosthesis and bra necessitated by breast surgery and replacement of these items when required by normal wear, a change in medical condition or additional surgery
- Oxygen and rental equipment for its administration
- Penile prosthesis when impotence is caused by a covered medical condition, a complication directly resulting from a covered surgery or an injury to the genitalia or spinal cord and other accepted treatment has been unsuccessful (lifetime maximum of two prostheses)
- Rental or purchase (decided by Aetna) of durable medical equipment such as wheelchairs, hospital beds and respiratory equipment (combined rental fees may not exceed full purchase price)
- Wig or hairpiece to replace hair lost due to radiation therapy or chemotherapy for a covered condition, up to a lifetime maximum of $100.

Prescription Drug Services. Some items are covered through AdvancePCS (see Prescription Drugs").

► Emergency Room Care

Emergency room care treats medical conditions that threaten loss of life or limb, or may cause serious harm to the patient's health if not treated immediately. Examples of conditions that might require emergency room care include, but are not limited to:
- Bleeding that will not stop
- Chest pain
- Convulsions
- Major burns
- Severe breathing problems
- Unconsciousness or confusion, especially after a head injury.

If you need emergency room care, follow these steps:
- Go to the nearest hospital emergency room immediately
- When you arrive, show your medical plan ID card
- If possible, call Aetna within 48 hours (the phone number is printed on the front of your ID card); otherwise, you may receive a lesser benefit (if you're unable to call, have a friend, relative or hospital staff person call for you).

If you have a medical emergency as determined by the plans, you receive network-level benefits for network or non-network care. If your condition does not qualify as a medical emergency, but care is urgently needed, see "Urgent Care."

► Family Planning

Medical Services. The following services are covered (Aetna processes the claims):
- Insertion of intrauterine birth control devices (IUDs)
- Tubal ligation
- Vasectomy
- Voluntary termination of pregnancy.

The KingCare plans do not cover:
- Procedures to reverse voluntary sterilization
- Sexual dysfunction treatment or related diagnostic testing.

Prescription Drug Services. Birth control pills and devices requiring a prescription are covered (AdvancePCS processes the claims).

► Growth Hormones

Growth hormones are covered for certain medical conditions and must be preauthorized if you receive network or non-network care. If you receive this drug from your provider, your provider bills Aetna for the drug and its administration. If you get the drug from a retail pharmacy or mail order service, AdvancePCS pays for the drug and Aetna pays for administration by your provider, if needed.

► Hearing Aids

Hearing aids (including fitting, rental and repair) are covered up to $500 per 36-month period.

► Home Health Care

Home health care services are covered if:
- Care takes the place of a hospital stay
- Part of a home health care plan, and
- Provided and billed by a licensed Washington State home health care agency.

Home health care is payable up to 130 visits per year. Network providers obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for home health care.

Covered services include:
- Nursing care
- Occupational therapy
- Physical therapy
- Respiratory therapy
- Restorative therapy
- Speech therapy (restorative only).

Services and prescription drugs provided and billed by a home infusion therapy company are also covered if the company is licensed by the state as a home health care agency. The prescription drug claims are processed by AdvancePCS when they're filled at a retail pharmacy or through the mail order service.

The following services are not covered:
- Custodial care, except by home health aides as ordered in the approved plan of treatment
- Housecleaning
- Services or supplies not included in the written plan of treatment
- Services provided by a person who resides in your home or is a family member
- Travel costs or transportation services.

► Hospice Care

Hospice care is a coordinated program of supportive care for a dying person by a team of professionals and volunteers. The team may include a physician, nurse, medical social worker or physical, speech, occupational or respiratory therapist.

Hospice care services are covered up to six months if:
- Care takes the place of a hospital stay
- Part of a hospice care treatment plan, and
- Provided and billed by an organization licensed as a hospice by Washington State.

Network providers obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for hospice care.

Covered services include:
- Drugs and medications (Aetna processes claims for prescription drugs provided by the hospice during the course of medical treatment; AdvancePCS processes claims for retail pharmacy and mail order drugs)
- Emotional support services
- Family bereavement services
- Home health services
- Homemaker services
- Inpatient hospice care
- Physician services
- Respite care for family members who care for the patient.

An extension of these benefits may be granted by a written request from your physician to Aetna.

The following services are not covered:
- Any services provided by members of the patient's family
- Financial or legal counseling (examples are estate planning or the drafting of a will)
- Funeral arrangements
- Homemaker, caretaker or other services not solely related to the patient, such as:
  - House cleaning or upkeep
  - Sitter or companion services for either the plan participant who is ill or for other family members
  - Transportation
- More than 120 hours of respite care in any three months of hospice care
- Pastoral counseling.

► Hospital Care

Inpatient. Covered inpatient hospital care includes:
- Hospital services, such as
  - Anesthesia and related supplies administered by hospital staff
  - Artificial kidney treatment
  - Blood, blood plasma and blood derivatives
  - Drugs provided by the hospital in the course of medical treatment are covered through Aetna; outpatient, retail pharmacy and mail order drugs are covered through AdvancePCS
  - Electrocardiograms
  - Operating rooms, recovery rooms, isolation rooms, cast rooms
  - Oxygen and its administration
  - Physiotherapy and hydrotherapy
  - Splints, casts and dressings
  - X-ray, radium and radioactive isotope therapy
  - X-ray and lab exams
- Intensive care or coronary care units
- Newborn nursery care after covered childbirth, including circumcision
- Semiprivate room, patient meals, general nursing care (private room charges are covered only up to the hospital's semiprivate rate).

Network providers obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for inpatient care other than that necessary for up to 48 hours following a vaginal childbirth, 96 hours following a cesarean section.

If a hospital stay continues from one calendar year to the next, a second deductible is not required for further treatment before discharge. Coverage continues at 100% until discharge, if the out-of-pocket maximum is met for the year hospitalization began.

Convalescent, custodial or domiciliary care is not covered.

Outpatient. Covered outpatient care includes:
- Diagnostic and therapeutic nuclear medicine in a hospital setting
- Hospital outpatient chemotherapy to treat malignancies
- Outpatient surgery
- Surgery in an ambulatory surgical center in place of inpatient hospital care.

► Infertility

Covered infertility expenses include:
- Embryo transfer
- Intrauterine and intravaginal artificial insemination
- In vitro fertilization.

Infertility benefits are payable up to $25,000 for your lifetime.

The plans do not cover:
- Assisted reproductive technology (ART) methods not listed above
- Donor expenses
- Donor sperm and banking services
- Drugs to treat infertility
- Procedures to reverse voluntary sterilization
- Services for dependent children
- Sexual dysfunction.

► Injury to Teeth

The services of a licensed dentist are covered for repair of accidental injury to sound, natural teeth. Injuries caused by biting or chewing are not covered. Treatment must begin within 30 days of the accident, and all services must be provided within 12 months of the date of injury. This benefit is limited to $600 per accident.

► Inpatient Care Alternatives

Your physician may develop a written treatment plan for care in an equally or more cost-effective setting than a hospital or skilled nursing facility. If the alternative setting plan is approved by your KingCare plan, all hospital or skilled nursing facility (depending on what kind of care the alternative is intended to replace) benefit terms, maximums and limits apply to the inpatient care alternatives.

► Lab, X-ray and Other Diagnostic Testing

Covered services include:
- Lab or x-ray services, such as ultrasound, nuclear medicine, allergy testing
- Screening and diagnostic procedures during pregnancy as well as related genetic counseling (when medically necessary for prenatal diagnosis of congenital disorders)
- Services to diagnose or treat medical conditions of the eye by a physician or licensed optometrist; eyewear and routine vision exams and tests for vision sharpness are not covered under this benefit (see Vision Service Plan booklet for additional information).

"Preventive Care" in this booklet describes benefits for routine screenings such as hearing tests and mammograms.

► Maternity Care

Maternity care is covered if provided by a:
- Physician (a registered nurse whose specialty is midwifery is considered a physician for this purpose), or
- Provider licensed as a midwife by Washington State.

Covered maternity care includes:
- Complications of pregnancy or delivery
- Hospitalization and delivery, including home births and licensed birthing centers for low-risk pregnancies
- Postpartum care
- Pregnancy care
- Related genetic counseling when medically necessary for prenatal diagnosis of congenital disorders
- Screening and diagnostic procedures during pregnancy.

The plans do not cover:
- Home pregnancy tests
- Lamaze classes
- Maternity care for children.

Group medical plans and health insurers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurers may not require that a provider obtain authorization for prescribing a length that doesn't exceed 48 hours (or 96 hours).

You don't need to preauthorize the length of stay unless it exceeds the 48 or 96 hours.

► Mental Health Care

Inpatient and outpatient mental health care is covered if provided by a licensed psychiatrist (MD), licensed psychologist (PhD), licensed master's level mental health counselor, licensed nurse practitioner (ARNP), community mental health agency licensed by the Department of Health or licensed state hospital.

Covered services include:
- Individual and group psychotherapy
- Inpatient care or day treatment care instead of hospitalization (must be in a licensed medical facility)
- Lab services related to the covered provider's approved treatment plan
- Marriage and family therapy
- Physical exams and intake history
- Psychological testing.

Depending on individual medical needs, other benefit options may be available under the medical case management provision of these plans (see "Case Management" in this booklet).

Inpatient mental health care is limited to 30 days per year. Outpatient mental health care is limited to 52 visits per year. When deemed appropriate by Aetna, two unused outpatient visits may be traded for one inpatient day, or vice versa. Network providers obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for inpatient mental health care. You also may receive these benefits by calling King County's Making Life Easier Program. A staff member will obtain preauthorization approval as necessary and refer you to a provider for treatment.

The plans do not cover:
- Biofeedback
- Custodial care

- Specialty programs for mental health therapy not provided by these plans
- Treatment of sexual disorders.

► Neurodevelopmental Therapy

The plans cover inpatient and outpatient neurodevelopmental therapy for covered family members age six and younger.

Neurodevelopmental therapy services are covered only if the care is:
- Furnished by providers authorized to deliver occupational therapy, speech therapy and physical therapy
- Prescribed by the patient's physician, and
- Provided because significant deterioration in the child's condition would result without such services, or to restore and improve function of the child.

Network providers obtain preauthorization for your care as necessary. If you see a non-network provider you must obtain preauthorization for inpatient neurodevelopmental therapy.

► Newborn Care

The plans cover newborns under the mother's coverage for the first three weeks, as required by Washington State law. To continue the newborn's coverage after three weeks, the newborn must be eligible and enrolled by the deadline as described in the Important Facts booklet.

► Physician and Other Medical/Surgical Services

The following services are covered (Aetna processes the claims):
- Immunization agents or biological sera, such as allergy serum
- Medical care in the provider's office
- Nutritional counseling by a licensed nutritionist or dietitian when medically necessary for disease management
- Physician services for surgery, anesthesia, home, office, hospital and skilled nursing facility visits
- Second opinions obtained before treatment (the provider giving the second opinion must be qualified, either through experience or specialist training); a second opinion may be required to confirm the medical necessity of a proposed surgery or treatment plan.

► PKU Formula

The plans cover the medical dietary formula that treats phenylketonuria (PKU) through Aetna.

► Prescription Drugs

Prescription drug services for KingCare members are provided by AdvancePCS, a separate provider not affiliated with Aetna. AdvancePCS issues a separate prescription card to KingCare members to use when filling prescriptions at AdvancePCS network pharmacies or from the AdvancePCS mail order service, AdvanceRx.com.

You may order up to a 30-day supply from a retail network pharmacy or up to a 90-day supply per prescription or refill through the mail order service (if you use the mail order service, you pay the 90-day copay amounts even if your prescription is written for less than a 90-day supply).

What's Covered. The following items are covered (Advance PCS processes the claims):
- Contraceptives (oral, injectable, vaginal, topical and implantable)
- Controlled substance 5 over-the-counter drugs (see Glossary booklet for a definition)
- DESI drugs (see Glossary booklet for a definition)
- Emergency allergic reaction kits
- Emergency contraceptives

- Glucagon emergency kit
- Injectable prescription drugs purchased at a retail pharmacy or through mail order (for some, preauthorization may be required; some injectables may be covered under medical services)
- Insulin and diabetic supplies
  - Alcohol swabs
  - Blood glucose testing strips
  - Glucose tablets
  - Injection devices (such as Novopen)
  - Insulin administered by pen/cartridge or other special injection devices
  - Insulin needles and syringes
  - Insulin/predrawn syringes
  - Keytone testing strips
  - Lancets
  - Lancet devices
  - Monitors
  - Urine glucose testing strips
- Legend drugs unless specified otherwise (see Glossary booklet for a definition)
- Ostomy supplies
- Prenatal vitamins
- Smoking cessation drugs requiring a prescription (claims for non-prescription nicotine patches are covered through Aetna and reimbursed at network rates)
- Topical smoking cessation patches whether prescription or over-the-counter
- Viagra, if used to treat impotency or penile dysfunction and preauthorized.

What's Not Covered. The following items are not covered by AdvancePCS:
- Anorexiants
- Any over-the-counter medication, unless otherwise noted
- Blood products
- Cosmetic/hair loss medications
- Experimental medications that do not have the 11-digit code assigned under FDA regulations
- Infertility medications
- Therapeutic devices or appliances, including hypodermic needles, syringes (except those used for insulin and in the course of administering medical treatment), support garments and other non-medical substances regardless of intended use
- Vitamins (except prenatal).

An extensive nationwide network of pharmacies has agreed to dispense covered prescription drugs to plan participants at a discounted cost and not to bill plan participants for any amounts over the copays.

Using a Network Pharmacy. Here's how it works:
- Choose a network pharmacy (contact AdvancePCS for a list of network pharmacies or to find one near you; see Resource Directory booklet)
- Show your AdvancePCS prescription card to the network pharmacist each time you want a prescription filled or refilled (your Aetna medical card is not used for prescription drug services)
- Pay the copay for each covered new prescription or refill
- There are no claim forms to submit; the network pharmacy bills the plan directly.

If you do not show your prescription card, and the network pharmacy cannot reach AdvancePCS to confirm you are covered, you will need to pay the pharmacy in full and submit a claim for reimbursement to AdvancePCS.

Using a Non-Network Pharmacy. If you fill a prescription through a non-network pharmacy, you must pay the cost of the prescription first and then submit a claim for reimbursement from AdvancePCS. Reimbursement is based on the rates AdvancePCS pays its network pharmacies. Generally, a non-network provider charges more than what AdvancePCS pays its network pharmacies. If so, you or your family members pay the difference.

Mail Order Service. The mail order service is for maintenance drugs (drugs you must take on an ongoing basis). The first time you use the mail order service, fill out the patient information questionnaire on the order form available at AdvancePCS.com or by calling AdvancePCS (see Resource Directory booklet). This questionnaire needs to be completed only once. The information is maintained by AdvancePCS and assists in cross-checking future medicines for drug allergies.

Each time you order a new prescription, send the order form with your payment directly to the address on the form. You must include your physician's written prescription with your order form and payment. Once you've submitted the order form, you may obtain refills through the AdvancePCS website or by calling the toll-free number on the back of your prescription card.

All prescriptions are processed promptly and are usually returned to you within 14 days. If you don't receive your medicine within 14 days or have questions, contact the mail order service through the Web or by phone.

If you use the mail order service, you pay the 90-day copay amounts even if your prescription is written for less than a 90-day supply. (There is no non-network mail order service.)

► Preventive Care

The following preventive care is covered:
- Breast exams, pelvic exams and Pap tests every year for women
- Immunizations, including annual flu shots (immunizations for travel are not covered)
- Mammograms every year for women over 40 (or as determined by provider for high-risk patients)
- Routine physicals and hearing tests.

Immunizations (well-baby), routine physicals and hearing tests are covered according to the following schedule. The schedule is a guideline; benefits may be available for more frequent care depending on the situation. Contact Aetna for details (see Resource Directory booklet).

Age	Preventive Care
Birth to 1 year	Routine newborn care plus 5 well-baby office exams
1- 5 years	4 well-child visits, with 1 visit in each of these age groups: 1-2, 2-3, 3-4, 4-5
6 - 12 years	3 well-child visits, with 1 visit in each of these age groups: 6-8, 8-10, 10-12
13 - 17 years	2 well-teen visits, with 1 visit between ages 13-15 and 1 visit between ages 15-17
18 - 25 years	1 well-adult visit
26 - 49 years	1 well-adult visit every 4 years
50 years and older	1 well-adult visit every 2 years

► Radiation Therapy, Chemotherapy and Respiratory Therapy

Inpatient and outpatient services are covered for medically necessary radiation, chemotherapy and respiratory therapy when prescribed by your physician.

► Reconstructive Services

Reconstructive surgery to improve or restore bodily function is covered, subject to the plans' review and approval. The plans do not cover cosmetic surgery to improve physical appearance unless it is medically necessary.

Covered individuals receiving benefits for a mastectomy who elect breast reconstruction in connection with the mastectomy, as determined in consultation with the patient and attending physician, have these benefits:

- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas
- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the healthy breast to produce a symmetrical appearance.

These reconstructive benefits are subject to the same annual deductible and coinsurance provisions as other medical and surgical benefits.

► Rehabilitative Services

The plans cover medically necessary inpatient and outpatient rehabilitative care designed to restore and improve a physical function lost due to a covered illness or injury. This care is considered medically necessary only if significant improvement in the lost function occurs while the care is provided and the attending physician expects significant improvement to continue. To verify whether coverage for rehabilitative services applies or continues to apply, Aetna has the right to obtain written opinions from the attending physician concerning whether and to what extent the significant improvement is occurring.

Inpatient services are covered to a maximum of 60 days per calendar year and must be in a licensed hospital or skilled nursing facility. Outpatient services are covered to a maximum of 60 visits for all therapies combined per calendar year and must be furnished by a licensed medical provider.

These plans do not cover services or expenses related to schools or other non-medical facilities that primarily supply educational, vocational, custodial and/or rehabilitative support training or similar services.

► Skilled Nursing Facility

Skilled nursing facility services are covered if:

- Provided and billed by a licensed Washington State skilled nursing facility, and
- The care takes the place of a hospital stay.

Let your provider know a written plan of treatment is required for these services to be covered. Network providers obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for skilled nursing facility care.

Prescription drugs are covered through Aetna when provided by the skilled nursing facility and used by the patient during a period of covered skilled nursing facility care; outpatient, retail pharmacy and mail order drugs are covered through AdvancePCS.

The following services are not covered:

- Custodial care
- Services or supplies not included in your physician's written plan of treatment
- Services provided by a person who resides in your home or is a family member
- Travel costs.

Skilled nursing facility confinement for developmental disability, mental conditions or primarily domiciliary, convalescent or custodial care is not covered.

► Smoking Cessation

These plans cover:

- Acupuncture to ease nicotine withdrawal
- Hypnotherapy to ease nicotine withdrawal
- Prescription drugs to ease nicotine withdrawal are covered through AdvancePCS; claims for non-prescription nicotine patches are covered through Aetna and reimbursed at network rates

- Smoking cessation programs (non-network benefits available only); to receive benefits for a smoking cessation program, you must complete the full course of treatment.

No medical plan benefits are provided for:
- Books or tapes
- Inpatient services
- Nicotine gum
- Vitamins, minerals or other supplements.

The lifetime maximum for smoking cessation is $500.

► TMJ Disorders

Diagnosis and treatment of temporomandibular joint disorder and myofascial pain (including nightguards when prescribed by a medical doctor due to a TMJ diagnosis) are covered as a medical condition up to $2,000 per calendar year. Non-network services must be preauthorized and in general use and acceptance by the medical/dental community to relieve symptoms, promote healing, modify behavior and stabilize the condition.

Additional benefits are available through the dental plan (see Washington Dental Service Plan booklet).

► Transplants

Covered services include professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery and follow-up care as well as certain donor expenses. Benefits may include travel and accommodations for a recipient's family member or parent and up to $100 a day for the family member's food and lodging if the care is provided out of state. These benefits are payable only until the family member's presence is no longer necessary, as determined by the plans.

Network providers obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for transplants.

You are not eligible for organ transplant benefits until the first day of the 13th month of continuous coverage under a KingCare plan whether or not the condition is preexisting or an emergency.

If your provider recommends a transplant (even if it's not listed in this section) call Aetna immediately to discuss your situation, determine if the transplant is covered and, if so, make the necessary arrangements.

The following human transplants are covered:
- Bone marrow including peripheral stem cell rescue
- Cornea
- Heart
- Heart-lung
- Kidney
- Liver
- Lung (single or double)
- Pancreas with kidney.

Transplant Recipients. If you are a transplant recipient, all of your services and supplies (including transportation to and from designated facilities) are covered. (Designated facilities are specific facilities identified by Aetna and authorized to perform certain transplant procedures for plan participants.) You must be accepted into the facility's transplant program and continue to follow that program's protocol.

Transplant Donor. Transplant donor expenses are covered if the recipient is a plan participant. Covered services include:

- Bone marrow testing and typing of the brothers, sisters, parents and children of the patient who needs the transplant; testing and typing of any other potential donor are not covered
- Evaluation of the donor organ or bone marrow, its removal and transport of both the surgical/harvesting team and donor organ or bone marrow (if used for a covered transplant)
- Locating a donor, such as tissue typing of family members and other donor procurement costs.

What's Not Covered. These plans do not cover:

- Donor costs for a transplant not covered under these plans, or for a recipient who is not a plan participant (however, complications and unforeseen effects from a plan participant's organ or bone marrow donation are covered as any other illness)
- Donor costs for which benefits are available under other group coverage
- Non-human or mechanical organs, unless deemed non-experimental and non-investigational by these plans
- Organ or bone marrow search or selection costs (including registry charges), unless described as covered.

► Urgent Care

These plans cover treatment for conditions that are not considered a medical emergency but may need immediate medical attention. Examples of urgent conditions include:

- Ear infections
- High fevers
- Minor burns.

If you need urgent care during office hours, call your physician's office for assistance. After office hours, call your physician's office and contact the on-call physician. Depending on your situation, the physician may provide instructions over the phone, ask you to come in to the office or advise you to go to the nearest emergency room.

If you see a network provider for urgent care, you receive network-level benefits; if you see a non-network provider, you receive non-network benefits. However, if you need emergency care, it is covered at network levels whether you see a network or non-network provider.

Expenses Not Covered

Medical Services. In addition to the exclusions or limits described in other sections of this booklet, the KingCare plans do not cover:

- Benefits that are covered by the following agencies or programs (or benefits that would be covered by these agencies or programs if the KingCare plans didn't cover them), except as required by law:
  - Any federal, state or government program (except for facilities in Aetna's list of network providers)
  - Government facilities outside the service area
  - Medicare
  - Workers compensation or state industrial coverage
- Benefits payable under any automobile, medical personal injury protection, homeowner, commercial premises coverage or similar contract (reimbursement to Aetna is made without reduction for any attorney's fees, except as specified in the contract)
- Biofeedback
- Charges that exceed UCR amounts
- Charges that, without these plans, would not have to be paid, such as services performed by a family member
- Chronic mental health condition treatment (inpatient or outpatient) such as for mental retardation, mental deficiency or forms of senile deterioration resulting from service in the armed forces, declared or undeclared war or voluntary participation in a riot, insurrection or act of terrorism
- Cosmetic surgery except:
  - For all stages of reconstruction on the non-diseased breast to make it equal in size to the reconstructed diseased breast following mastectomy

  - For reconstructive breast surgery on the diseased breast necessary because of a mastectomy
  - For congenital anomalies of a dependent child
  - When related to a disfiguring injury
- Court-ordered services or programs not judged medically necessary by the plans
- Custodial care solely to assist with normal daily activities (such as dressing, feeding and ambulation) or any other treatment that does not require the services of a registered nurse or licensed practical nurse
- Dental charges, except for natural teeth injured in an accident while covered by the plans (this treatment must be within one year of the accident)
- Dependent child maternity treatment, services or drugs
- Exams, tests or shots required for work, insurance, marriage, adoption, immigration, camp, volunteering, travel, license, certification, registration, sports or recreational activities
- Experimental or investigational services, supplies or settings
- Fertility services such as reversal of voluntary sterilization, voluntary removal of birth control devices implanted under the skin (for example, Norplant), any fees relating to donor sperm, menotropins (such as Pergonal) or related drug therapy, or surrogate parenting fees
- Foot care considered routine such as hygienic care, treatment for flat feet, removal of corns or calluses, corrective orthopedic shoes, arch supports or orthotics unless needed for diabetes or other covered conditions
- Hospitalization solely for diagnostic purposes when not medically necessary
- Injuries sustained:
  - By an intentional overdose of a legal prescription, over-the-counter drug, illegal drug or other chemical substance
  - From suicide or attempted suicide (unless the patient was being treated by a mental health professional immediately before or after attempt)
  - While engaged in any activity that results in a felony conviction
  - While performing any acts of violence or physical force
- Jaw abnormalities, malocclusions or any related appliances
- Non-approved drugs and substances (those the FDA has not approved for general use and labeled "Caution – limited by federal law to investigational use")
- Not medically necessary services and supplies to treat illness or injury, except for newborns and unless otherwise specified
- Obesity surgery or other procedures, treatment or services such as gastric intestinal bypass surgery (unless preauthorized)
- Schools or other non-medical facilities that primarily provide educational, vocational, custodial and/or rehabilitative support, training or similar services
- Services of a provider related to you by blood, marriage, adoption or legal dependency
- Sexual dysfunction or transsexualism surgery, treatment or prescriptions
- Third-party required treatment or evaluations such as those for school, employment, flight clearance, summer camp, insurance or court
- Vision tests unless due to illness or injury; these plans also do not cover:
  - Contact lenses (except for cataract surgery)
  - Eyeglasses or their fittings
  - Orthoptics
  - Radial keratotomy or similar surgery for treating myopia
  - Visual analysis, therapy or training.

Prescription Drug Services. In addition to the exclusions or limits described in other sections of this booklet, the plans do not cover:

- Charges that exceed the amounts AdvancePCS pays its network pharmacies
- Drugs for dependent child's maternity
- Infertility drugs, including Viagra (unless preauthorized)
- Non-approved drugs and substances (those the FDA has not approved for general use and labeled "Caution – limited by federal law to investigational use")
- Sexual dysfunction or transsexualism drugs.

Coordination of Benefits

► Coordination of Benefits between Plans

King County plans coordinate benefits under a non-duplication policy between primary and secondary plans. That means if a plan is primary, it pays first; if it is secondary, it pays only the difference between what the primary plan paid and what the secondary plan would have paid if it was primary.

If you and a family member both have your own health coverage (medical, dental and vision) and you cover each other as dependents under your plans, your own plans are primary for each of you and secondary for each other.

While the plan covering an individual as an employee is primary and pays first, the following guidelines determine what plan is primary for dependent children covered under two parents ("parents" in this case may not be blood related, but providing coverage through a marriage or domestic partnership):

- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, its provisions apply.)
- If the parents are divorced or legally separated, these rules apply:
  - If a court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility pays first
  - If there is no court decree, the plan of the parent with custody (or primary residential placement) pays before the plan of the parent without custody
  - If the parent with custody has remarried, the plan that covers the child is determined in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody.

If these provisions don't apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed pays first (unless the other plan doesn't have a provision regarding retired or laid-off employees).

The plans have the right to obtain and release data as needed to administer these coordination of benefit procedures.

► Coordination of Benefits with Medicare

If you keep working for the county after age 65 you may:

- Continue your medical coverage under a county plan and integrate the county plan with Medicare (the county plan would be primary).
- Discontinue your county medical coverage and enroll in Medicare. If you choose this option, your covered family members are eligible for continuation of coverage under COBRA for up to 36 months (see "COBRA" in the Important Facts booklet).

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is secondary to a plan covering a person as an active employee or family member of an active employee. Medicare is primary in most other circumstances.

If you have any questions about how your coverage coordinates with Medicare, contact your medical plan (see the Resource Directory booklet).

Filing a Claim

► How to File a Medical Claim with Aetna

If you receive care from Aetna network providers, they submit claims for you.

If you receive care from a non-network medical service provider, you pay the provider in full, and it's your responsibility to submit a claim to Aetna or have the provider submit one for you. Claim forms are available from the plans (see Resource Directory booklet).

When submitting any claim, you need to include your itemized bill. It should show:
- Patient's name
- Provider's tax ID number
- Diagnosis or ICD-9 code
- Date of service
- Itemized charges from the provider for the services received.

You also need to provide:
- Your name (if you were not the patient)
- Your Social Security number (or unique identifier number if assigned one by your plan)
- Group number 725069.

For prompt payment, submit all claims as soon as possible. Generally, your plan will not pay a claim submitted more than 12 months after the date of service. If you can't meet the 12-month deadline because of circumstances beyond your control, the claim will be considered for payment when accompanied by a written explanation of the circumstances.

► How a Claim is Reviewed by Aetna

Aetna reviews your claim and notifies you or your provider in writing within the following timeframes:
- Within 72 hours for urgent claims. Urgent claims are those where your provider believes a delay in treatment could seriously jeopardize your life, health or ability to regain maximum function, or cause severe pain that can't be controlled adequately without the care being considered. Urgent claims can be submitted by phone or fax. You will be notified of the claim review decision by phone, followed by a written notice.
- Within 15 days for pre-service claims (within 30 days if an extension is filed). Pre-service claims are those where your plan requires you to obtain approval of the benefit before receiving the care. The plan may ask for a one-time extension of 15 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.
- Within 24 hours for concurrent claims. Concurrent claims are those for continuation of services previously approved by the claim administrator as an ongoing course of treatment or to be provided over a certain period.
- Within 30 days for post-service claims (within 60 days if an extension is filed). Post-service claims are claims that aren't urgent, pre-service or concurrent. Your plan may ask for a one-time extension of 30 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.

The claim administrator reviews your claim, applying plan provisions and their discretion in interpreting plan provisions, and then notifies you of the decision within the timeframes listed above.

► If the Claim is Approved by Aetna

If the claim is approved and there is no indication the bill has been fully paid, payment for covered services is made to the provider. If the bill indicates full payment has been made to the provider, payment for covered services is made directly to you.

Reimbursement to non-network providers is for the maximum allowable fees paid by your plan. If a non-network provider charges more than what AdvancePCS pays its network pharmacies, you or your covered family members pay the extra amount.

► If the Claim Is Denied by Aetna

If the claim is denied, you are notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that the carrier reviewed in making the determination.

► How to File Prescription Drug Claims with AdvancePCS

The majority of prescription claims are processed on line at the time of dispensing from the network pharmacy, so a paper claim is not required.

If you fill a prescription through a non-network pharmacy, you pay the pharmacy in full, and it's your responsibility to submit a claim form to AdvancePCS. Claim forms are available from the plan (see Resource Directory booklet).

When submitting a pharmacy claim, you need to include a completed claim form, along with the original prescription receipt, containing the following information:

- Patient's name
- NABP number (if listed on label)
- Prescription number
- Date filled
- Dollar amount
- Quantity
- Days supply
- NDC
- For compounds, the ingredients and the NDC# of the highest priced legend drug used (listed on label).

After your claim is processed, you receive written notice describing the approval (amount submitted, amount covered/allowed and amount of reimbursement) or the reason for denial. Payment for covered prescriptions is made directly to you. Reimbursement typically takes about 14 days.

If a non-network provider charges more than the rates AdvancePCS pays its network providers, you pay the extra amount.

Appealing Denied Claims

► Claims Denied for Reasons Other Than Eligibility

If a properly filed claim is denied in whole or in part, the Aetna or AdvancePCS service representative notifies you and your provider with an explanation in writing. When a claim is denied for any reason other than eligibility, follow the steps described in this section. However, when a claim is denied for eligibility reasons, follow the steps described in "Claims Denied Due to Eligibility."

If you or your representative disagrees with the claim denial, you may try to resolve any misunderstanding by calling the appropriate claim administrator (Aetna or AdvancePCS) and providing more information. If you'd rather communicate in writing or the issue isn't resolved with a call, you may file a written appeal.

You have 180 days after receiving a claim denial notice to file a written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

The claim administrator reviews the written appeal and notifies you or your representative of their decision within these timeframes:

- Within 72 hours for urgent appeals
- Within 14 days for pre-service appeals (within 30 days if an extension is filed)
- Within 20 days for post-service appeals (within 40 days if an extension is filed)
- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

The claim administrator reviews your appeal, applying plan provisions and their discretion in interpreting plan provisions, then notifies you of the decision within the timeframes listed above. If the claim appeal is denied, you

are notified in writing of reasons for the denial. The claim administrator has sole discretionary authority to determine benefit payment under the plans; their decisions are final and binding.

If the appeal is denied, legal remedies may be pursued, but you or your representative must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within two years after the event the claim is based on or you forfeit your right to legal action.

You must file an appeal within the given timeframe or you may forfeit your right to further consideration of your claim.

► Claims Denied Due to Eligibility

If you have eligibility questions or believe you've had a claim denied because your plan indicates you or a family member is not covered, call Benefits and Retirement Operations at 206-684-1556. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or your eligibility issue can't be resolved with a phone call, you or your representative (referred to as "you" in the rest of the section) may file a written appeal. You have 180 days after receiving an eligibility determination notice (from the county or your plan) to submit a written appeal. It must include:

- Your name and address as well as each covered family member's name and address (if applicable)
- Hire letter or job announcement, or retirement determination of eligibility
- Your employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a family member)
- Reason for the appeal.

Send eligibility appeals to:

King County Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these timeframes:

- Within 72 hours for urgent appeals (call 206-684-1556 to file an urgent appeal)
- Within 14 days for pre-service appeals (within 30 days if an extension is filed)
- Within 20 days for post-service appeals (within 40 days if an extension is filed)
- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under these plans; its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits and Retirement Operations determines you're entitled to the benefits.

If you believe your eligibility appeal was denied because relevant information or documents were not considered, Benefits and Retirement Operations offers the option of filing an eligibility appeal addendum within 60 days after receiving the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address for eligibility appeals, but to the attention of the Benefits and Retirement Operations Manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. Decisions of the manager are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be within two years of the date you or your family member is denied plan participation, or you forfeit your right to legal action.

Release of Medical Information

As a condition of receiving benefits under these plans, you and your family members authorize:

- Any provider to disclose to the plans any requested medical information
- The plans to examine your medical records at the offices of any provider
- The plans to release to or obtain from any person or organization any information necessary to administer your benefits
- The plans to examine records that would verify eligibility.

The plans will keep this information confidential whenever possible, but under certain necessary circumstances, it may be disclosed without specific authorization.

Certificate of Coverage

When your coverage under one of these plans ends, you automatically receive a certificate of health plan coverage. This is an important document and should be kept in a safe place. You may take this certificate to another health plan to receive credit against a preexisting condition limit for the time you were covered under one of the KingCare plans.

Converting Your Coverage

If you're no longer eligible for the KingCare medical coverage described in this booklet, you may transfer your coverage to an Aetna insured conversion plan without evidence of insurability. The plan you convert to will differ from the benefits described in this booklet; if it includes a prescription drug benefit, claims will be processed by Aetna, not AdvancePCS (you may not transfer your AdvancePCS coverage to an insured conversion plan).

If you transfer your coverage to an Aetna insured conversion plan, you must pay premiums, which may be higher than the amount you currently pay (if any) for these benefits.

You will not be able to convert to the individual policy if you are eligible for any other medical coverage under any other group plan (including Medicare).

To apply for a conversion plan, you must complete and return an application form to Aetna within 31 days after this medical coverage terminates (see Resource Directory booklet). You will not receive the application or information about conversion plan coverage unless you request it from Aetna.

Extension of Coverage

If you or your covered family members are hospitalized when your medical coverage terminates, the plans continue to provide coverage until discharge. Coverage ends on the date of discharge or when you or your covered family member reaches the plan maximums, whichever comes first.

If you or your covered family member is totally disabled, and your coverage ends for any reason except plan termination, medical coverage for only the disabling condition may be extended for 12 months at no cost to you. The disabled person may choose either this medical extension or COBRA coverage, but electing the extension means they forfeit the right to elect COBRA coverage and convert to an individual policy. Other family members may be able to elect coverage through COBRA (see "Continuation of Health Benefits If You Become Disabled" in the Important Facts booklet).

Payment of Medical Benefits

These medical and prescription drug benefits are funded by King County, meaning these are "self-funded" plans where King County is financially responsible for claim payments and other costs.